

# MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

63-025399

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 282 Primary Registration District No. 4424 Registrar's No. 99

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

FILED JUL 11 1963

1. PLACE OF DEATH a. COUNTY <u>Polk</u>		2. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Clair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Humansville</u>		c. CITY OR TOWN <u>Osceola</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Dimmit Memorial Hosp;</u>		d. STREET ADDRESS (If outside, give location) <u>Yes</u> <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Rosa Miller Parke</u>			4. DATE OF DEATH Month Day Year <u>July 1, 1963</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/3/78</u>	9. AGE (last birthday) <u>85</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeping</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>St. Clair County Mo. USA</u>	
13a. FATHER'S NAME <u>George Miller</u>		13b. MOTHER'S MAIDEN NAME <u>Eliza Warden</u>		14. NAME OF HUSBAND OR WIFE <u>Jewell Brown, Collins Mo.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>[REDACTED]</u>		

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>metastatic Carcinoma of Breast</u> DUE TO (c) <u>Carcinoma of Right Breast</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>?</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>May 1963</u> to <u>July 1, 1963</u> and last saw her alive on <u>July 1, 1963</u> . Death occurred at <u>9:30 A</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>R. A. Robinson</u> (Degree or title) <u>MD</u>		22b. ADDRESS <u>Humansville, Mo.</u>	
22c. DATE SIGNED <u>7/3/63</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>7/5/63</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Kings Prairie</u>	
23d. LOCATION (City, town, or county) <u>Gerster Missouri</u>		24. FUNERAL DIRECTOR ADDRESS <u>Goodrich Funeral Home, Osceola Missouri</u>	
DATE RECD. BY LOCAL REG. <u>July 9, 1963</u>		REGISTRAR'S SIGNATURE <u>Ralph Warden per J.A.</u>	

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 12 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed JB Sanden

Licensed Embalmer No. 3039

P. O. Address Osceola MN

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

No permit issued

J.B.